Payment Error Rate Measurement (PERM)
REQUEST FOR RECORDS COVER SHEET
PERM-ID: [||PermID||]

Date: [||MRReSubDate||]

Patient Name: [||BeneficiaryName||]
Date of Birth: [||BeneficiaryDOB||]
Beneficiary ID: [||BeneficiaryID||]
Date(s) of Service: [||DOSFrom||] - [||DOSTo||]

Provider Number: [||ProviderID||]
Provider Name: [||ProviderName||]

Category 1: Inpatient Hospital Services

Record Submission Due Date: [||MedrecDueDate||]

Please indicate # of pages in submission:

_____ pages

Inpatient Hospital Services: Acute Inpatient, Long-Term Acute, Acute Inpatient Rehabilitation

Please submit all *applicable* documents from the listing below to support the claim sampled.

- **Admission History and Physical *(H&P)***
- **Physician Orders and Progress Notes (*signed and dated*)**
- **Medication Administration Record *(MAR)***
- **Discharge Summary**
- Admission Face Sheet/Coding Summary
- Emergency Department Record and Admission Order/Notes
- Nursing Assessment/Notes
- Consultation Reports/Notes
- Cardiovascular and Respiratory Reports
- Itemized Billing Sheet (*if required based on payment method*)
- Ambulance Services
- Dialysis Treatment Record/Notes
- Operative and Procedure Reports/Notes
- Anesthesia *(Pre- and Post-Op)* and Peri-operative Record/Notes *(with start and stop times)*
- Laboratory and Diagnostic Tests/Reports
- Labor and Delivery Record/Notes
- All Transfer Forms
- Physical Therapy: Evaluation/Re-evaluation/Notes
- Speech Language Pathology: Evaluation/Re-evaluation/Notes
- Occupational Therapy: Evaluation/Re-evaluation/Notes

Note: *Please submit the complete medical record with signatures as appropriate for the service(s) billed for the sampled claim. The documents that are bolded are frequently required for this category and service type. Please be sure to include these with your document submission, if applicable to the sampled claim.*

Please help ensure accurate processing by placing this page on top of the records you are submitting.